Testimony of
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Hearing on Proposal to Reduce Child Deaths Due to Maltreatment
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Good morning Chairman Paulsen, Ranking Member Doggett and Members of the Subcommittee. Thank you for the invitation to join you today.

I am David Sanders, executive vice president of Systems Improvement at Casey Family Programs, a national foundation committed to improving the lives of vulnerable children and families in America by building communities of hope.

Casey Family Programs has been serving children in foster care for more than 45 years. We believe that the goals of the nation around securing well-being for all children should be about both: 1) keeping children who have been abused and neglected safe from further harm; and 2) preventing abuse and neglect, the possibility of child deaths, and the need for foster care in the first place by strengthening vulnerable families and their communities.

Extrapolating from federal government statistics, every 24 hours in America, on average:

- Approximately 2,000 children are confirmed as victims of child abuse and neglect.

- Nearly 700 children are removed from their families and placed in foster care.

- About four children die as a result of child abuse and neglect, most of them before they reach their fifth birthday.

That is every day in America.

And these child deaths, 1,537 in 2010, are considered to be an under-count, according to the 2011 U.S. Government Accountability Office (GAO) report on child maltreatment and fatalities. Indeed, 2010 was the first time in a decade that the number of child deaths due to maltreatment declined instead of increased. But herein – in the data – lies the problem. Whether the numbers reported go up or down, for a variety of reasons there exists a common underlying concern among professionals in the field, scholars and many others about the accuracy of the data.

When Casey Family Programs developed its 2020: Building Communities of Hope strategy seven years ago, we were motivated to do so, in part, because of the number of child fatalities at that time. We had asked ourselves, what would happen to America's most vulnerable children if nothing changed. If we were to continue on the same trajectory we were on in 2005, we estimated that by the year 2020, at least

22,500 children will have died from abuse and neglect. At least, because as I explained, that estimate is most likely based on an under-counting of child fatalities.

Though we have made significant strides toward keeping children safe – children who have come to the attention of child welfare - we cannot fully or adequately address the issue of child fatalities until we know the full scope of the problem. Not until we have accurate numbers to give us a clearer picture of what's going on.

How do we go about getting reliable data that tell the whole story? Only after we know what we're dealing with – what the problem looks like – only then can we develop effective strategies and solutions.

We thank the Members of this Subcommittee for their leadership and commitment to reducing child fatalities due to abuse and neglect. The proposal would establish a commission to develop a national strategy and recommendations on this issue. We commend the vision and believe that such a commission would provide an opportunity to further inform how we can prevent child fatalities.

We offer two comments for your consideration. First, we agree it is important the 12 commission members represent a number of the key expertise areas outlined in the proposal. While the proposal says each member should possess at least on area of expertise, it is important that the commission represent a broad range of issues. As currently drafted, it appears possible that all of the commission members could come from a single area of expertise.

Second, the proposal appears to limit the purview of the commission to programs funded under titles IV and XX of the Social Security Act. There are a broad array of programs that provide upfront prevention and intervention services such as Medicaid, maternal and child health programs, substance abuse funding, etc. We, therefore, urge that a broader spectrum of programs be explored for inclusion.

Casey Family Programs "Improving Child Safety and Preventing Fatalities" Forums

In an effort to influence and mobilize national efforts to prevent child maltreatment related fatalities, Casey Family Programs launched a series of forums in the fall of 2011. The Administration on Children Youth and Families, and the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention (CDC) joined Casey Family Programs in hosting these events that were attended by experts, policy-makers, advocates, researchers, practitioners and leaders in the field of child welfare and public health.

The first forum entitled "Improving Child Safety and Reducing Child Maltreatment Fatalities" was held at the Urban Institute in Washington D.C. on November 9-10, 2011 with a group of 35 experts, policy-makers, advocates, researchers, practitioners and child welfare leaders. The second forum, which was attended by over 80 participants was held on March 21 and 22, 2012 in Atlanta, GA and focused on "Applying Public Health Approaches to Improve Safety and Prevent Child Fatalities." The Third forum took place on June 28-29, 2012 in Nashville, TN and was attended by over one hundred participants. The event was co-hosted by the Tennessee Department of Children's Services and focused on "Improving Safety and Preventing Child Fatalities: Focusing on Child Protection. Most recently, on December 11, 2012, Casey Family Programs hosted a "Safety Action Planning Summit" which was attended by public child welfare and public health representatives from ten states and the District of

Columbia. These jurisdictions met with experts to develop and refine specific action plans targeted towards improving child safety and preventing fatalities.

These forums provided us with the tremendous opportunity to explore this issue from different perspectives and focused on three major topics:

- **Measurement:** Developing more accurate ways to classify and count maltreatment related fatalities as a means of informing policy and practice, as well as developing better child safety performance measures.
- **Child Protection Policy and Practice:** Informing child protection policies and practices for reducing child maltreatment related fatalities.
- **Public Health Approach:** Exploring a new approach to child protection that emphasizes public health strategies for preventing child maltreatment fatalities.

The following six lessons learned emerged from these discussions:

- **We can succeed**. Public health and safety engineering efforts have reduced deaths and injuries in the U.S. from many causes that initially seemed intractable. This has been true even when, at the beginning of the effort, those causes seemed deeply ingrained in cultural and individual beliefs (drunk driving, smoking) and driven by interactions between human error (medical errors) and sheer, unpreventable bad luck (plane crashes).
- **Successful strategies are comprehensive.** This lesson emerges above all from the public health successes which are comprehensive in multiple ways. First, they are multi-level, potentially including components at the level of the individual, the family, the community, service systems and public policy, as well as broader public attitudes and beliefs. Second, they target several different levels of prevention – immediate prevention of death or injury, as well as more "upstream" prevention targeted at high-risk groups or individuals. They may also include universal prevention efforts, targeted towards an entire community or nation.
- **Strategies are not limited to any one sector or agency**. The theme of multi-agency and multi-sector strategies, including health, law enforcement and education, as well as child welfare systems and service providers, received particular attention. Other sectors or partners identified included the media, elected officials, the broader public and anti-poverty and affordable housing experts and activists.
- **Successful strategies are focused.** Comprehensive isn't the same as trying to do everything. The key is a focused approach, based on data and evidence, with high-impact opportunities that can make a difference. In the public health world, continuous attention is paid to what is working and to gaps that need to be filled.
- **High quality data, as well as other kinds of research evidence, are essential to inform the strategy and assess its results.** This starts with surveillance–being able to count and measure the problem. This strategy also includes data to identify families at the highest risk, which is necessary to target upstream prevention. And it includes data to place deaths, injuries and "near-misses" in a systemic context, to inform system improvements that have been crucial to safety engineering successes. In addition, evidence synthesized from past research should inform the initial choices of programs and strategies, which then can be tracked for effectiveness and fine-tuned over time.

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- **On the data side, we have some important knowledge and experience right now – yet there are also glaring gaps.** We clearly know more than we are now putting into practice, but there are also substantive knowledge gaps.

The following presents some of the major themes that emerged from the Safety Forums convened by Casey Family Programs[1]:

1) Risk Factors for Severe Maltreatment and Fatalities

Large-sample research in California linking birth records and child protection services (CPS) records has found that a report for child maltreatment before the age of 5, whether substantiated or not, is a risk factor for a fatality from intentional or unintentional injury. The research using linked data found that factors at birth including Medicare health insurance, Black race, younger maternal age, and lack of established paternity for the child are associated with higher risk for report of child maltreatment, and especially for report of neglect, during the first 5 years of life. Of interest was whether children reported for nonfatal maltreatment subsequently faced a heightened risk of unintentional and intentional injury mortality during the first 5 years of life. Findings indicate that after adjusting for risk factors at birth, children with a prior allegation of maltreatment died from intentional injuries at a rate that was 5.9 times greater than unreported children and died from unintentional injuries at twice the rate of unreported children. A prior allegation to CPS proved to be the strongest independent risk factor for injury mortality before the age of five.[2]

Similarly other research suggests that there are risk factors that are predictive of severe child maltreatment and fatalities. For example, researchers found that rates of Abusive Head Trauma (AHT) identified among children less than 5 years of age increased significantly at several major pediatric hospitals between 2007 and 2009, and were associated with increased economic hardship at the community level.[3]

2) Child Maltreatment as a Public Health Issue

A significant proportion of child maltreatment-related deaths occur in families who have no history of involvement with the child welfare system. Since many of these cases are outside the oversight of child welfare, their numbers would not be reflected in agency reports. Therefore, it would be prudent for us to look at this issue of child deaths, not just through the lens of child welfare, but from a broader public

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[1] Chahine et al. (2012), Casey Family Programs Child Safety Forum Summaries: The Road Ahead: Policy and Practice Innovations Needed to Improve Child Safety and Prevent Fatalities. (unpublished)

[2] Putnam-Hornstein, E., Webster, D., Needell, B. & Magruder, J. (2011). "A Public Health Approach to Child Maltreatment Surveillance: Evidence From a Data Linkage Project in the United States". *Child Abuse Review* 20, 256-273. See also Putnam-Hornstein, E. (2011). "Report of Maltreatment as a Risk Factor for Injury Death: A Prospective Birth Cohort Study". *Child Maltreatment* 16(3), 163-174.

[3] Berger, R.P., Fromkin, J.B., Stutz, H., Makoroff, K., Scribano, P.V., Feldman, K., Tu, L.C., & Fabio, A. (2011). "Abusive Head Trauma During a Time of Increased Unemployment: A Multicenter Analysis". *Pediatrics* 128 (4), 637-643. See also Wood, J.N., Medina. S.P., Feudtner, C. Luan, X. Localio, R., Fieldston, E.S., Rubin, D.M. (2012). Local Macroeconomic Trends and Hospital Admissions for Child Abuse, 2000–2009. *Pediatrics*. Published online.

health perspective. A public health approach to the prevention of child maltreatment fatalities focuses on the health of populations rather than just the individuals, and aims to prevent critical events *before they occur.* This approach is more efficient, more effective, and is associated with better outcomes, compared to treatment after harm occurs. Prevention may take three basic forms:

a) Primary prevention efforts are intended to reduce risk and enhance protective factors in the general population (all children and families). *EXAMPLES*: Requiring use of child safety seats in all cars with young child passengers; delivery of safe sleeping guidelines to all parents of infants and toddlers.

b) Secondary prevention efforts consist of interventions designed to reduce risk and enhance protective factors among specific population sub-groups known to be at greater risk for child fatalities and serious injuries. *EXAMPLE*: Home visiting parent support and education programs targeted to low-income, first-time parents.

c) Tertiary prevention efforts, by contrast, are intended to reduce and prevent subsequent harm among families *where abuse or neglect has already occurred*. *EXAMPLES*: In-home safety planning in families who are subjects of child maltreatment reports; protective custody and out-of-home placement of child victims of abuse and neglect.

While most child protection activities in the United States have traditionally relied on tertiary prevention, the value of broader public health approaches is that they focus energy and resources on more "upstream" primary and secondary prevention activities, and thus have the potential to keep more children safe while reducing and preventing the trauma and disruption associated with removing children from their homes.

As demonstrated by the research, many high-risk family situations can be identified very early in the life of a child, providing opportunity for proactive support and intervention which may help save lives and prevent serious injuries**.** Information available from birth records regarding a small set of risk factors can be utilized to target high-risk children and families for outreach and offers of voluntary services.

Dr. Fred Rivara and Dr. Brian Johnston conducted a review of successful public health efforts for Casey Family Programs. They found that public health research has demonstrated certain types of interventions can help to reduce and prevent child fatalities and serious injuries, and some effective steps to prevention are neither costly nor difficult to implement.[4] Automobile child safety seats, bicycle helmets, and safety fences around swimming pools are examples of simple and effective steps that have saved many lives. The promotion of safe sleeping practices ("Back to Sleep") is an example of an initiative that reduced preventable child deaths and injuries and could likely save additional lives if consistently promoted by organizations that come into contact with families that have infants and toddlers in the home.

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[4] Rivera, F. P. and Johnston, B. (2012), Paper prepared for Casey Family Programs: "Effective Primary Prevention Programs in Public Health and Their Applicability to the Prevention of Child Maltreatment" (unpublished).

Public information campaigns are integral to effective public health efforts to reduce and prevent deaths and injuries. They also play a critical role in informing the public about the work of CPS agencies and in framing child safety as a community responsibility. Comprehensive media relations strategies are also recommended by child welfare leaders who have successfully incorporated public health approaches into agency policy and practice. Using information to help change culture within agencies and communities, and perseverance over time in change efforts, have been critical factors in the success of effective prevention campaigns. Twenty years ago it would have been difficult to find a bicycle helmet in a child's size, and available helmets were often unattractive to appearance-conscious consumers. Today, helmets are available in a wide range of styles and sizes, and helmet use by bicycle riders has increased tremendously. Lessons from this and other injury prevention campaigns can inform new and ongoing efforts to reduce and eliminate child fatalities and serious injuries.

It is encouraging that the CDC's Division for Violence Prevention is exploring the use of experiential learning tools (simulation modeling) to more effectively communicate the importance of addressing Adverse Childhood Experiences (ACEs) as an important public health issue. These tools will be embedded in a larger facilitated process that will culminate in participants – individual employers, community coalitions of employers, and/or the broader community – in developing action plans to ensure safe, stable, nurturing childhoods by building community capacity and citizen resiliency. Computerized simulation modeling can be a valuable tool in engaging community stakeholders in steps towards preventing child maltreatment injuries, and can be effective in supporting group learning processes within organizations.

3) **Informing child protection policies and practices for reducing child maltreatment related fatalities**

There are several areas that need to be considered in order to improve child protection policies and practices. The public's perception of child welfare in this country is generally painted by media reports of isolated cases of tragedy. Not only is this an inaccurate picture of the child welfare system, but worse, drives public will against that system's leaders and leaves them especially vulnerable to the fallout that occurs when cases of severe abuse and child death hit the front page. The gap between public perception and the realities of child welfare administration leaves the systems wanting for resources and allies and drives public policy in ways that are not always the best for keeping children safe. Thus, a key challenge in child welfare is transforming a culture of public blame leading to agency defensiveness and secrecy into a culture of learning. A key lesson from the successes in the safety engineering world is the importance of looking at incidents from a systems perspective and developing a "safety culture." One of the components of such a culture is that staff feel safe from unfair blame and as a result openly share information that the agency can use to learn. Also critical is building the Child Protection's decision-making and workforce capacity, skills, and training as well as advancing and supporting promising community and cross-systems approaches to preventing maltreatment and fatalities.

Dr. Eileen Munro, a professor of Social Policy at the London School of Economics and Political Science recently completed a review of the child protection system at the request of the British government. Dr. Munro was invited by Casey Family Programs to present at the Safety Forum held in Nashville in June 2012. Dr. Munro commented that the approach to child welfare management has not worked because it is based on a misunderstanding of the human factors in decision making as well as a mistaken

understanding of the nature of the skills required for child protection work. Dr. Munro applied a system's perspective to decision making in child protection, and she urged participants to be cognizant that errors in child protection are inevitable; and that agencies need to steadily work at minimizing errors without imagining that steadily increasing procedural requirements is the only or best approach to achieving this goal.   Dr. Munro asserted that agencies need to create organizational environments in which ongoing learning about how to improve practice can occur and which value feedback from the recipients of agency services. She emphasized the need to reduce the punitive response to child deaths in which specific persons are blamed and punished. [5]

Dr. Tina L. Rzepnicki, a professor at the University of Chicago also presented at the Safety Forums. She similarly described the adoption and implementation of the Root Cause Analysis method of critical event review in Illinois – the application of a structured investigative and analytic process originally designed to achieve in-depth understanding of adverse outcomes in other high-risk enterprises (e.g., chemical factory explosions, airline crashes, failed military operations) to child protection. Dr. Rzepnicki advanced that system failures need to be reviewed and understood across systems (e.g., mental health, medical, law enforcement). Defensive practice does not avoid risk but displaces it. A safety/learning environment embraces mistakes as opportunities for adaptive learning to take place but for this to happen, it is necessary to make explicit the kinds of errors that are not acceptable (subject to consequences) and have clear guidelines for reporting mistakes and near misses. Transparent communication is essential. Such an environment also encourages critical thinking and active problem solving by peers in group context. [6]

Dr. Rzepnicki also addressed approaches for transforming child protection agencies into "High Reliability Organizations" during the Safety Forums. High Reliability Organizations (HROs) are organizations with systems in place that are exceptionally consistent in accomplishing their goals and avoiding potentially catastrophic errors". [7] Principles of HRO were first embraced by industries in which past failures had led to catastrophic consequences: airplane crashes, nuclear reactor meltdowns, and other such disasters. These industries found it essential to identify weak danger signals and to respond to these signals strongly so that system functioning could be maintained and disasters could be avoided. These principles are now being applied in health care and there is some emerging interest about potential applicability in child protection. For example, Tennessee is currently engaged in an effort to implement High Reliability Organizing to reduce child fatalities and serious injuries.

Finally, preventing child maltreatment injuries and deaths requires ongoing collaboration among a range of agencies across service sectors and the community. This cannot be accomplished by public child welfare agencies alone. There are examples from around the country of how cross system and community partnerships can improve child safety and prevent maltreatment.

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[5] Munro, Eileen, The Munro Review of Child Protection, Part One: A Systems Analysis, 2010 available at www.education.gov.uk

[6] Rzepnicki, T., Johnson, P., Kane, D.; Moncher, D.,Coconato, L., Shulman, B. (2012). "Learning from data: The beginning of error reduction in Illinois child welfare". In Rzepnicki, T.L., McCracken, S., and Briggs, H.E., eds. *From Task-Centered Social Work to Evidence-Based and Integrative Practice: Reflections on History and Implementation.* Chicago: Lyceum Books, Inc.

[7] Rzepnicki, T. L., Johnson, P.R., Kane, D., Moncher, D., Coconato, L. Shulman, B. (2010). Transforming child protection agencies into high reliability organizations: A conceptual framework. *Protecting Children, 25* (1). 48-62.

4) **Measurement and Classification of Child Fatalities**

Experts agree that improving the measurement and classification of child fatalities is critical to understanding and preventing child maltreatment and fatalities. Improved consistency in identifying and counting child maltreatment fatalities at the state and national level is seen as essential to determining whether efforts to reduce and prevent maltreatment fatalities are effective. A review of the child welfare, criminal justice, forensic, medical and public health literature highlights the lack of reliable and valid sources of local, state and national data on child maltreatment fatalities. The identification and investigation of child maltreatment fatalities face serious challenges that together lead to the well-documented undercount of child abuse and neglect related deaths. The reasons for this under-ascertainment and underreporting of child maltreatment deaths have been described in detail in several studies.

Building effective cross-sector, multi-agency collaborations are essential to obtaining accurate data on the incidence of preventable child deaths and serious injuries, and for the implementation of successful prevention efforts. Multidisciplinary local and state Child Death Review Teams play a critical role in identifying patterns in child deaths and serious injuries, in identifying common risk factors, and in developing and implementing preventive efforts. Moving beyond blame to focus on prevention is key to learning from critical events to avert similar incidents in the future.

For example, the child maltreatment fatality numbers in the National Child Abuse and Neglect Reporting System (NCANDS) - one of the primary sources of national child maltreatment data - are considered to be an undercount because most states include only child deaths from families known to child protection agencies. Research has demonstrated that more than half of the children who die from maltreatment are from families that were not known to or were never investigated by child protection agencies. State child protection agencies vary widely in their definitions of maltreatment adding to the concerns that the aggregate estimates are likely to be incomplete. However, being able to count child maltreatment deaths reliably and accurately over time and across jurisdictions is essential for making system improvements and developing long-term comprehensive child maltreatment prevention strategies.

Similar limitations exist for each of the other major data systems that are used to track child maltreatment fatalities. For example, law enforcement data sources tend to only track homicides (i.e., death at the hands of another).

Following the first Safety Forum in November 2011, Casey Family Programs brought together about a dozen nationally-recognized experts in several disciplines to form a Child Fatalities Measurement Workgroup. The objective of the Workgroup is to recommend more accurate ways to count and classify child fatalities so that ultimately the nation is better positioned to further improve child safety and prevent fatalities. The Workgroup will develop options for national, state, and local policy makers to consider in developing an ongoing strategy to improve measurement of maltreatment fatalities by early 2013. Our work builds on the findings of the GAO report and we are working in partnership with the Administration on Children, Youth and Families and the CDC.

To date, the Workgroup discussed several issues including (a) the reasons and limitations to improving coroners' and medical examiners' determinations of causes of child fatalities; (b) proposals for linking administrative data bases from multiple agencies to arrive at more accurate counts of child maltreatment fatalities; (c) the need for standard definitions of neglect that can be applied to accidental deaths in classifying child maltreatment deaths; (d) potential for learning from the standards for substantiation developed for use in the military services; (e) ways of improving NCANDS measures of child maltreatment fatalities (f) and ways that the National Death Review data base can be enhanced.

We are encouraged by the CDC and the National Center for Child Death Review (NCCDR) joint Sudden Unexpected Infant Death (SUID) Initiative. Under contract from the Health Resources and Services Administration (HRSA), the NCCDR currently provides training and support to state and local child death review (CDR) teams that now exist in every state. Initially in partnership with 17 states, NCCDR developed a web-based Case Reporting Form for collecting data from the team reviews. This online tool is provided to states and teams for no cost and is now in use in over 30 states. The aggregate multi-state data from this system have been used to explore the circumstances surrounding multiple causes of death to identify potential prevention opportunities (e.g., toddler drowning, violent deaths, sudden cardiac deaths, and now infant sleep related deaths). For the SUID initiative, NCCDR has worked with CDC to develop an expanded version of the Case Reporting Form to supplement the data elements on sleep related infant deaths. CDC has funded seven states to pilot the new form and procedures for quality data collection. To date, the results are impressive. All seven states have been able to collect all the major data elements with a confirmed extremely high level of completeness and quality in a timely manner. Several additional states have already adopted the new SUID data collection form. This Initiative demonstrates the feasibility of integrating the new public health child maltreatment definition into NCCDR's web-based data collection system and having it implemented effectively by state child death review teams.

Another hopeful example is how the U.S. Armed Forces were able to achieve greater consistency to the classification of child maltreatment. Amy Slep and Richard Heyman, both from New York University, presented to the Workgroup on their extensive research and development work which has culminated in a computer-guided decision matrix tool to support decision making among diverse stakeholders in determining whether to substantiate child maltreatment allegations. The tool was developed under contract for the U.S. Air Force, and is now used by all branches of the U.S. Armed Forces.

Cross-agency collaboration in tracking child deaths is possible and a variety of local models exist. Rules have also been developed for joining information regarding child fatalities from multiple data bases in order to derive the most accurate possible count of maltreatment fatalities. However, lessons learned about how best to do this still need to be discussed. A practical way of tracking injuries and near-misses is also urgently needed.

Casey Family Programs has used its national platform and its resources to elevate this issue with a particular focus on engaging state child welfare administrators and other key voices. We stand ready to work with this commission or any other group or organization focused on child fatalities.

Thank you for the opportunity to share these remarks with you, and, above all, thank you for your commitment to the well-being of children and families.